

Exhibit 11



HANCOCK
MEDICAL CENTER

ED-OP

REGISTRATION

STAY TYPE 3 - E.R.		SERVICE CODE - DESC ER- ER	
MEDICAL RECORD NO. 002232		ADMIT DATE 03/31/2008	ADMIT TIME 03:06
PATIENT'S LEGAL NAME (L, F, M) DAHL DOYLE		A/R NO. 30018094	
SOCIAL SECURITY NO. 426-23-0795	PRIOR STAY DATE 03/12/2008	ACCOUNT NUMBER 30016864	PATIENT'S LEGAL ADDRESS 6016 E MADISON RD
RESPONSIBLE PARTY DAHL DOYLE	RESPONSIBLE PARTY'S ADDRESS 6016 E MADISON RD	CITY/STATE BAY ST LOUIS MS	ZIP 39520
RESPONSIBLE PARTY'S EMPLOYER DISABLED	EMPLOYER'S ADDRESS NA	CITY/STATE NA	ZIP 99999
SOCIAL SECURITY NO. 426-23-0795	OCCUPATION UNE	CITY/STATE NA	ZIP 999-999-9999
INS. CODE	PAYER	CLAIM PROCESSING ADDRESS	CITY/STATE
INSURED	REL INFO		
CERTIFICATE / SSN / HIC ID NO.	GROUP NAME	INSURANCE GROUP NO.	
INS. CODE	PAYER	CLAIM PROCESSING ADDRESS	CITY/STATE
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INS. CODE	PAYER	CLAIM PROCESSING ADDRESS	CITY/STATE
INSURED	REL INFO		
CERTIFICATE / SSN / HIC ID NO.	GROUP NAME	INSURANCE GROUP NO.	
NOTIFY IN EMERGENCY ARLENE JOHNSON		HOME TELE 228-216-0137	WORK TELE 000-000-0009
ATTENDING PHYSICIAN SAHERI KAMRAN		PHYSICIAN CALLED	
CHIEF COMPLAINT		CONSULTING OTHER PHYSICIAN	
		ADM. INITIALS MHS	



E.R.
DAHL DOYLE
002232
03/31/08

30018094
M 40
07/16/67
SAHERI K

MEDICAL RECORDS

4/ 87342

PROC 12011

DEF-00189

Head / Facial Injury

#38 E.D. Physician Record



E.R. 30016094
 NAME DOYLE H 40
 002332 07/16/67
 03/31/08 ZARERI K

Diagnostic Considerations: circle potential diagnoses

Intracranial bleed
 subdural hematoma
 epidural hematoma
 skull fx
 concussion
 closed head trauma
 facial injury
 mandible fx
 blowout fx
 facial fx
 laceration
 contusion

X-ray: (Read by: E.P. Rad.)

1- ☐ nl 2- ☐ nl
 3- ☐ nl 4- ☐ nl

Treatment / Medical Options / Course:

Medications / Orders

O2 at: IV of:
 Tetanus: dT, 6cc IM / TIG
 Pain meds:
 Antibiotics

Response

Medical Decis. Making: L1: straightforward; L2-3: low/complex; L3: mod; L4: hi
 Slash box if ordered; nl: check normals; circle and note abnormal

Lab:

☐ CBC: nl nl except
 Hct nl Hb nl
 WBC nl
 Segs nl Bands nl Monos nl
 Lymphs nl Eos nl
☐ Chem: nl nl except
 NA nl K nl Glu nl
 Cl nl CO2 nl Anion gap nl
 BUN nl Creat nl
☐ ETOH nl ☐ Drug screen
☐ PT, PTT, INR nl
☐ nl

ABG: on RA / O2: nl % / LpH: nl PO2 nlPCO2 nl HCO3 nlP. Ox nl %: on RA / O2: nl % / Lnl / hypoxic☐ EKG: NSR nl intervalsnl QRS nl ST-T wavesCompared to: unchanged / changedRead by: E.P.☐ Cardiac monitor: NSR

Wound Repair:

Location	Length / Depth	Repair
1) <u>1.5</u> cm superficial / SQ / IM	<u>4</u> DermaBond / staples # of <u>4</u> - <u>50/24</u> # of <u>0</u> - <u>0</u>	
2) <u>1.5</u> cm superficial / SQ / IM	DermaBond / staples # of <u>0</u> - <u>0</u> # of <u>0</u> - <u>0</u>	

Comments:

1 sensat intact 1 vasc. intact
 Level of contamination: 2 clean / min / mod / severe
 Anesthesia: local / digital block cc of 0 cc of 0 cc of 0
prep Suture removal instruct: days
Explored no F.B. / F.B. identified revised F.B. removed
irrigat debrided undetermined revised F.B. removed
 Hemostasis: min = 1, mod = 2, extensive = 3

Procedure: see addendumCritical Care: minutesCourse: same / better / worse

Consultation / Other data reviewed:

Consulted Dr: nl (time)Suggests: admit / discharge / will seeCase discussed with: patient / family / other

Reviewed / discussed with Radiologist:

Reviewed: NH / EMS / RN / Old Records / PT Quest

Clinical Impression:

Disposition:

home admit ICU / monitor / OR / med. / surg.
 Transfer to:

Admit physician:

Condition: better / worse / stable / expiredInstructions given: written verbalFollow up: PMD / other in days / pm / as scheduledRestrictions: off work hmd. duty gym school days

Discharge Rx:

Sig: nl date nl Attend. / Resid. / PA / NPSee: Addendum Attending note date nl Attend. / Resid. / PA / NP

Copies to:

☐ dictated☐ chart completed

DEF-00190

Head / Facial Injury #38
HANCOCK MEDICAL CENTER, BAY ST. LOUIS, MS 39520
 Check (✓) for normal, circle positive slash, negative, note findings
 Date: _____ E.P. time: _____ Age: _____ Wt: _____ Sex: M/F
 P: _____ BP: _____ RR: _____ Temp: _____

Chief Complaint: *LAC forehead*

HPI: 1-1.3: 1-3 elements; 1.4-1.6: 4+ elements

Onset: _____ undetermined

Occurred: _____ time _____ date
 _____ mins / hrs / days PTA

Location: *In ER*

Home / work
 Other: *SVL*

Activity / Mechanism of Injury:

unknown / found down
 fall / fight / alleged assault
 MVA / stab wound / CSW / burn

Injury description (quality):

deformity / laceration / scratch /
 abrasion / puncture / bite / F.B. / burn
 blunt trauma / confusion
 penetrating trauma

Modifying Factors:

witnessed / unwitnessed
 ambulatory at scene
 spinal immobilization

Factors: ETOH / drugs / seizure /
 syncope / suicidal attempt
 other:

ASSOC. EXS: _____ none

Headache:

Onset:

Course:

nausea / vomiting

LOC: none / unknown / dated / + LOC

Duration: _____ sec / mins / hrs

Remembers: incident / coming to hospital

GCS: _____ / 15

Bleeding: nose / ears / mouth / face / scalp

Discharge: nose / ears

vertigo / lightheaded / weak / fainting

seizures / behavior change

focal deficits / amnesia (retrograde / anterograde)

neck pain

Prior Rx: _____ none

EMS: Spinal immobilization

Other:

Location (anatomic):

*phi c
 phi neck
 phi*

E.R. 39018094

DATE: 002232

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Referred by: self / clinic / PMD / family / EMS
 Arrived by: EMS / walk-in / wheelchair
 Historic: patient / family / friend / EMS
 Hx limited by: Altered LOC / acuity / intoxication

Past, Family, Social History: 1-1.3: 1-3 areas; 1.4-1.6: 2 of 3 areas

PMH: none / unknown

prior head trauma

ETOH or drug abuse

psych probs

hypertension / CAD / CVA /

NIDDM / IDDM

Medx: none / see RN note

ASA / NSAIDs / coumadin

insulin / steroids

Allergies: none / see RN note

Tetanus current: yes / no

Physical Exam: 1-2.3: 2-4 organ/areas; 1.3: 5-7 organ/areas; 1.5: 8+ organ/areas

Exam limited by: urgency of condition / pt. uncooperative

Gen: Anxious: no / mild / mod / severe

Distress: no / mild / mod / severe

VS: nl

Orthostatic VS: 0-: _____

Nutritional status: nl / obese

Hydration: nl / dehydrated

Longboard / cervical immob. (ED / EMS) / IV / intubation / splint

Head / Neck (MS):

head trauma / skin nl

neck tend, ROM full

Eyes:

PERL

ids, conj. nl

EOM's full

cornea, chambers, discs nl

ENT:

nose nl

ext. ears, canals, TM's nl

mouth, teeth, oropharynx nl

TMJ's nl, jaw ROM nl

CV:

reg. rate, rhythm

heart sounds nl

Resp. Chest:

no resp distress

breath sounds nl, clear, equal

Spine / Pelvis / Ribs (MS):

thorac, lumbar inspect, palp nl

pelvis stable, inspect, palp nl

ribs stable, inspect, palp nl

GI / Abd / Flank:

abd nl appearance, BS nl

soft, nontender

flank nl appearance, nontender

rectal nl, heme neg

GU, Male:

ext. gen. nl

testis nl

GU, Female:

ext. gen. nl

cervix nl, no discharge

uterus, uterus nl

MS:

ROM nl without pain

joint nl, no muscle tenderness

strength, tone nl

Surgical Hx: none / unknown

brain surgery

previous trauma

Family Hx: none / unknown

seizures / aneurysms

Social Hx:



EMERGENCY DEPARTMENT NURSING RECORD

Sister Arlene Foster Attorney
216-0137

Name: Dahl, Doyle

Chief Complaint/Mechanism of Injury/Onset
Car hit to head and lacerated by police officer
on shoulder pain, lacerated to shoulder
arm in the lateral area, it stated he was shocked
in chest. It stated "he didn't shake with the police"

Pain Scale 0 1 2 3 4 5 6 7 8 9 10
5

Dull Sharp Ache Constant Intermittent Other Radiating

Treatment Prior to Arrival: None O₂ IV Collar/Immobil. Other

Tx at Triage: Ice Elevation Splint Sling Dressing None Other

Were you injured at work? Y N Y N N Unscheduled ED < 48 hr ☐ Yes ☐ No

Time of reassessment at Triage > 1 hr.

Vital Signs	Temp	HR	Resp	BP	SpO ₂	CBG
Time 0308	97.9	104	18	111/113	95%	
0345		102	18	116/101	95%	

Date 3-31-08 Time 0304 Triage Status I II III IV

Mode of Arrival Ambulance Walk Carried WC

Accompanied by Alone Spouse Parent Friend Other Police

Age 40 Sex M Private MD N MD Y Weight 180

Allergies: Medicines NKDA Substances None

Advance Directives Yes ☐ No Where Occupation

Tetanus Status Yes Use of Alcohol Y Tobacco (last cigarette) Y N

> 5 yr Yes Use of Drugs Y ppd 1 year/dog

Family Support Yes Lives alone Yes Homeless Yes At risk for abuse or neglect Yes

Medical History Seizure Hepatitis Cancer

Psychiatric Tuberculosis Migraines Renal

Diabetes Pulmonary HIV Sick Cell

Cardiac HTN Asthma Other

Surgeries: T&A Appy GB Back Cataracts

Other CSH band New 2007

Medication Dose Frequency Last Dose

Lamotrigine 10mg daily 3-30-08

Atenolol 25mg daily 3-30-08

INITIAL NURSING ASSESSMENT

Airway
☐ Effective
☐ Ineffective
Breathing
☐ Normal
☐ Labored
Breath Sounds
☐ Clear
☐ Wheezing
☐ Diminished
Circulation
☐ Skin color
☐ WNL
☐ cyanotic
☐ pale
☐ flushed
☐ jaundiced
Temperature
☐ warm
☐ cool
☐ diaphoretic

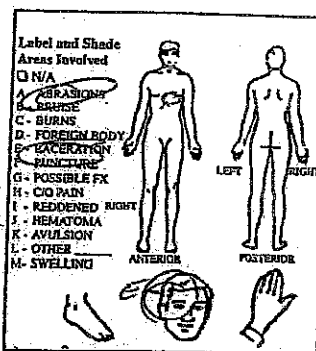
Capillary Refill
☐ < 3 seconds
☐ > 3 seconds
Mucous Membrane
☐ pink
☐ pale
Mental Status
☐ Alert
☐ orientation
☐ person
☐ time
☐ place
☐ confused
☐ lethargic
☐ anxious
☐ unresponsive
☐ A in M.S.
Bilateral Grips
☐ BNA
☐ equal
☐ weak
☐ R L

Cardiac
☐ Denies
☐ Chest pain
☐ Dull
☐ Sharp
☐ Epigastric
☐ Radiating
☐ Non-radiating
☐ Substernal
☐ SOB
☐ diaphoresis
☐ nausea
☐ Cough
☐ Denies
☐ Productive
☐ Non-Productive
☐ Eyes
☐ Denies
Visual Acuity
OD OS OU

GI
☐ Denies
☐ Nausea
☐ Vomiting
☐ X
☐ Diarrhea
☐ X
☐ Last BM
☐ Bleeding
☐ Emesis
☐ Rectum
☐ accompanied by
☐ SOB
☐ soft
☐ tender
☐ rigid
☐ distention
☐ rebound

OB/GYN/NA
LMP
Could you be pregnant?
☐ Yes
☐ No
☐ Hysterectomy
FHT
GR PARA AB
☐ Denies
☐ Vag d/c
☐ Vag bleeding
Urological
☐ Denies
☐ Frequency
☐ pain, burning
☐ incontinence
☐ retention
☐ hematuria
☐ nocturia
☐ Foley
☐ fever
☐ Discharge

Extremities:
☐ Denies C/O
Location
Pain
Pulse
Fallor
Paralysis
Parasthesia
Laceration: ☐ NA
Size: 1.5 cm
Appearance
Location
Bleeding
☐ Active
☐ Controlled



INFANT < 2 NA

Wet Diapers X
Crying/Quiescent
Strong/Normal
Whimpering
Moaning/
High-pitched
Head Circumference (as ordered)
Birth Weight

Hydration/Mucous
Membrane
Moist
Dry
Poor Skin Turgor

Color
Pink
Pale
Cyanotic

Activity Level
Playful
Fussy
Quiet

Fontanels
Flat
Bulging
Sunken
Immunizations
Due By Hx
UTD By Hx

Nurse's Notes Time to ER: 0304 O₂ @ CM
Two exam 2x in stable vital (0345) Exam by Dr
Gabeis completed for to (Dr) Gabeis and
from Dr Gabeis. The

Nursing Diagnoses:

☐ Alt in Comfort
☐ Cardiac Output, Decreased
☐ Gas Exchange Impaired
☐ Potential injury, potential
☐ Skin Integrity Impaired

☐ Trauma
☐ Breathing Patterns, Ineffective
☐ Fluid Volume, Alterations in
☐ Hyperthermia (Fever)
☐ Infection, Pain
☐ Mobility, Impaired
☐ Tissue Perfusion, Alt in

Time	Amt./Soln	Rate	Site	Needle	Init	Amt. Infused	Time D/c'd	Cath Intact	Init

Time	Medication	Amount	Route	Site	Init	Outcomes
0340	Nexpro Oint	0.9gr	Top			

Nursing discharge instructions: (0340) Return as needed follow
up in regular clinic, follow up in 10 days

Prescriptions Listed:

Accompanied by: alone spouse parent friend other police
PI outcomes ☐ unchanged ☒ improved ☐ Pain Scale 1/10
Notifications/Time
Police DSH Clergy Coroner SS Funeral Home
Nurse's Initials / Signature [Signature]

Reviewer's Initials